

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/01/2010
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an complaint investigation conducted on your facility from 1/26/10 to 3/1/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. One resident files was reviewed Complaint #NV00024183 was substantiated. See Tag Y976. The following deficiencies were identified:	Y 000		
Y 621 SS=D	449.2702(4)(b) Admission Policy NAC 449.2702 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (b) Requires restraint. This Regulation is not met as evidenced by:	Y 621		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/01/2010
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 621	Continued From page 1 NAC 449.2702 6. As used in this section: (b) "Restraint" means: (1) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (2) A manual method for restricting a resident's freedom of movement or his normal access to his body; or (3) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or his normal access to his body. Based on observation on 3/1/20, the facility failed to ensure 1 of 8 residents were not restrained with the use of full side bed rails. Severity: 2 Scope: 1	Y 621		
Y 976 SS=D	449.2754(7) Alzheimer's policies NAC 449.2754 7. The administrator shall ensure that the facility complies with the provisions of the statement required pursuant to subsection 5. This Regulation is not met as evidenced by: Based on interview and record review on 3/1/10, the administrator failed to ensure the facility staff took steps to prevent and respond appropriately when 1 of 8 residents wandered from the facility (Resident #1). Severity: 2 Scope: 1	Y 976		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.